COLLEGE OF REGISTERED NURSES OF ALBERTA (the "**College**")

DECISION OF THE HEARING TRIBUNAL

RE: CONDUCT OF **LISA STOCKDALE**, R.N. REGISTRATION #**77,903**

AS A RESULT OF A HEARING HELD BEFORE

THE HEARING TRIBUNAL

OF THE COLLEGE

11120 178 STREET

EDMONTON, ALBERTA

ON

SEPTEMBER 25, 2024

INTRODUCTION

A hearing was held on **September 25, 2024,** via Microsoft Teams videoconferencing by the Hearing Tribunal of the College to hear a complaint against Lisa Stockdale, R.N. registration #77,903

Those present at the hearing were:

a. Hearing Tribunal Members:

Bonnie Bazlik, RN Chairperson
John Bradbury, RN
Vince Paniak, Public Member
Andrew Otway, Public Member

b. Independent Legal Counsel to the Hearing Tribunal:

Natasha Egan

c. CRNA Counsel:

James Hart, Conduct Counsel

d. Registrant Under Investigation:

Lisa Stockdale (sometimes hereinafter referred to as "the **Registrant**")

e. Registrant's Labour Relations Officer/Legal Counsel:

Tamara Chivers, Labour Relations Officer

f. CRNA Staff

Marina Skoreiko, Hearings Coordinator as Clerk supporting the Chair of the Tribunal in procedural management of virtual proceeding technology.

PRELIMINARY MATTERS

Conduct Counsel and the Labour Relations Officer confirmed that there were no objections to the composition of the Hearing Tribunal or to the Hearing Tribunal's jurisdiction to proceed with the hearing. No preliminary applications were made.

The Chairperson noted that pursuant to section 78 of the *Health Professions Act*, RSA 2000, c. H-7 ("**HPA**"), the hearing was open to the public. No application was made to close the hearing. One member of the public (the Complainant) indicated an intention to observe but was not present at the commencement of the hearing.

Conduct Counsel confirmed that the matter was proceeding by Agreement.

ALLEGATIONS AND ADMISSION

The allegations in the Notice to Attend are as follows:

1. On or about June 15, 2022, the Registrant failed to demonstrate adequate knowledge, skill and/or judgment in their care of [Patient 1] when they did one (1) or more of the following:

    a. Failed to complete an adequate post-falls assessment, of the patient;

    b. Failed to assess or document the patient's post-fall vital signs, including neurological vital signs;

    c. Failed to notify the physician of the patient's fall;

    d. Failed to notify the patient's family of the patient's fall;

    e. Failed to adequately notify the Charge Nurse of the patient's fall; and

    f. Failed to adequately document her post-fall care of the patient in the patient's electronic medical record.

It is further alleged that that the Registrant's Conduct constitutes "unprofessional conduct", as defined in section 1(1)(pp)(i),(ii), and/or (xii) of the HPA, and in particular:

1. The Conduct underlying Allegation 1, or any part of it:

    a. Contravenes one (1) or more of the following: *Canadian Nurses Association Code of Ethics (2017)* ("***CNACE***"); *CRNA's Practice Standards for Regulated Members (2013)* ("***CPSRM***"); *CRNA's Documentation Standards for Regulated Members (2013)* ("***CDSRM***"); *CRNA's Entry Level Competencies for the Practice of Registered Nurses (2019)* ("***CELCPRN***"); and/or

    b. Contravenes one (1) or more employer policies, contrary to the *CPSRM*.

The Registrant has admitted to the conduct set out above in the allegations (the "Conduct") in the Agreed Statement of Facts and Liability dated June 27, 2024 (the "Agreement").

EXHIBITS

The following documents were entered as Exhibits:

Exhibit #1 – Notice to Attend a Hearing;

Exhibit #2 – Agreed Statement of Fact and Liability dated June 27, 2024;

Exhibit #3 – Joint Recommendations on Sanction;

Exhibit #4 – Course Catalogue; and

Exhibit #5 – Excerpt from *Jaswal* v. *Newfoundland Medical Board*, 1996 CanLII 11630 (NL SC) ("*Jaswal*").

SUBMISSIONS ON THE ALLEGATIONS

Submissions by Conduct Counsel:

Conduct Counsel made brief submissions. Conduct Counsel thanked the Registrant for her cooperation throughout the investigation and in getting to a consent hearing. He also thanked the Labour Relations Officer for her courtesies and professionalism throughout the process.

Conduct Counsel briefly reviewed the Agreement at Exhibit #2. He noted that this incident relates to the Registrant's lack of knowledge, skill and/or judgment in the care of a patient that fell. This includes a failure to complete an adequate post-falls assessment, lack of documentation of a post-falls assessment and failure to assess or document the patient's post-fall vital signs. The Registrant failed to comply with the AHS Falls Risk Management Post-Falls Review with respect to falls, fall prevention and risk management strategies. In addition, he submitted that the Registrant failed to notify the physician or patient's family of the fall. Further, the Registrant notified the charge nurse of the patient's fall only through an electronic sticky note in Connect Care rather than a verbal report.

Conduct Counsel advised that the Registrant admits that the Conduct is contrary to:

1. Responsibilities A1, A5, B4, D6, G1, G4 of the CNACE
2. Standards 1.1, 1.2, 1.4, 2.1, 2.2, 2.3, 2.4, 2.5, 2.7, 3.4, 4.1, 4.2, 4.3, 4.4, 5.2 and 5.3 of the CPSRM;
3. Standards 1.1, 1.2 and 1.4 of the CDSRM; and
4. Competencies 1.1, 1.2, 1.4, 1.5, 1.6, 1.7, 1.8, 2.1, 2.3, 2.13, 3.7, 3.8, 4.1, 4.3, 5.1, 7.1 and 7.6 of the CELCPRN;

Conduct Counsel submits that for these reasons the Conduct constitutes unprofessional conduct under the HPA.

Submissions by the Labour Relations Officer for the Registrant:

The Labour Relations Officer confirmed that the Registrant takes responsibility for her actions in this matter and noted that while the Registrant did assess the patient, she acknowledged that she did not do a full, adequate assessment. Further, although the oncoming night shift was notified through the sticky note, the Registrant admits that the steps taken were inadequate. The Labour Relations Officer believes that Conduct Counsel adequately reviewed the Agreement.

Procedural Matters:

A member of the public requested to join the hearing. After a brief adjournment to enable the Registrant and Labour Relations Officer to confer, the Hearing Tribunal was advised that there were no requests to close the hearing. Upon reconvening the hearing, the Chairperson explained the expectations for public observers.

Questions from the Hearing Tribunal:

Evidence

The Hearing Tribunal requested clarification regarding the specific location in the AHS policy of the requirement to notify the physician, family and charge nurse of a patient's fall. The Hearing Tribunal also requested that the parties direct the Tribunal to evidence in the record of the electronic sticky note.

After a brief adjournment, Conduct Counsel directed the Tribunals attention to the contemplation of a post-fall huddle as a way to communicate about the fall (page 3 of the AHS Falls Risk Management document). He submitted that the Complaints Director's position is that the most responsible health practitioner should be informed as part of the procedure in a fall of this manner. The Labour Relations Officer suggested that this may be a case of best practice as opposed to what is actually required under the policy.

With respect to the issue of the sticky note, Conduct Counsel advised that this was simply an admission from the Registrant regarding how the information was conveyed. The Labour Relations Officer noted that the matter of the sticky note was confirmed in the investigation report and by the Registrant as part of the Agreement.

Unprofessional Conduct

After an adjournment, the Tribunal sought clarification regarding agreement, if any, between the parties regarding the sections within the definition of unprofessional conduct. The Tribunal notes that the Notice to Attend alleges that the conduct constitutes unprofessional conduct under sections 1(1)(pp)(i), (ii) **and/or** (xii) of the HPA. Following adjournment, Conduct Counsel submitted on behalf of the College that the conduct would harm the integrity of the regulated profession under s. 1(1)(pp)(xii) of the HPA. The Registrant's Labour Relations Counsel submitted that the Conduct was only one incident where the Registrant did not complete the proper assessments and, as such, did not harm the integrity of the profession. In reply, Conduct Counsel stated he would allow the Tribunal to exercise their discretion on the matter.

After a brief adjournment, the Tribunal advised that it had sought and obtained advice from Independent Legal Counsel and wished Independent Legal Counsel to put that advice on the record. Independent Legal Counsel stated that she had advised the Tribunal that the issue of whether or not the Conduct admitted to harmed the integrity of the profession was no longer proceeding by agreement. As such, both parties had a right to adduce factual evidence and to make any legal or other submissions they wished prior to the Tribunal making a finding in this regard. Conduct Counsel advised that he had no further submissions. The Labour Relations Officer requested an adjournment to discuss with Conduct Counsel. Following an adjournment, Conduct Counsel and the Labour Relations Officer advised the Tribunal of their agreement that the Conduct did not constitute "conduct that harms the integrity of the regulated profession" under s. 1(1)(pp)(iix) of the HPA.

DECISION AND REASONS OF THE HEARING TRIBUNAL ON THE ALLEGATIONS

The Hearing Tribunal reviewed the exhibits and considered the submissions made by the parties.

The Hearing Tribunal considered the definition of unprofessional conduct under section (1)(1)(pp) of the HPA. The Hearing Tribunal finds that the Allegations are proven and that the Registrant's Conduct constitutes unprofessional conduct under section (1)(1)(pp) of the HPA, as follows:

> Unprofessional conduct means one or more of the following, whether or not it is disgraceful or dishonourable:
>
> (i) displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services; and
>
> (ii) contravention of this Act, a code of ethics or standards of practice.

The Hearing Tribunal finds the following facts to be proven, as agreed to in the Agreement at Exhibit 2.

Background

The Registrant graduated with an entry-level baccalaureate degree from the University of Alberta in April 2004 and registered with the College in July 2004. The Registrant had an active practice permit at all material times and does not have a discipline history with the College.

On January 17, 2023, the Complaints Director received a written complaint from a member of the public alleging concerns regarding the Registrant's care of a family member [Patient 1] of the Complainant (the "Complaint"). The Complaints Director of the College determined that a Hearing be held pursuant to the HPA.

Factual and Liability Admissions

The Registrant admits, as fact, that while employed as a RN at Alberta Health Services - Fort Saskatchewan Community Hospital ("FSCH") in Fort Saskatchewan, Alberta, the Registrant's practice fell below the standard expected of a RN when, on or about June 15, 2022, she engaged in the Conduct admitted to. The Registrant further admits that the Conduct constitutes "unprofessional conduct", as defined in section 1(1)(pp)(i) and (ii) of the HPA.

Further Factual Admissions

[Patient 1] was a patient on the IPU at FSCH. The IPU cares for Medicine, Surgery, Labour, Delivery and Recovery ("LDR") and Postpartum patients. The unit is divided into pods. There are 38 beds in total, 35 Medical/Surgical and 3 LDR beds. There is a combination of acute, palliative, and long-term care patients on the IPU.

The Registrant started working as a RN at FSCH IPU in July 2012. On June 15, 2022, the Registrant was working evenings. [Patient 1] was admitted to FSCH on February 28, 2022, via ambulance with a complaint of chest pain. At the time of her admission [Patient 1] was 85 years old.

[Patient 1] was in a private room located in close proximity to the nursing desk. At or around 20:00 on June 15, 2022, [Patient 1] suffered an unwitnessed fall. Earlier in the day, at 15:16, a different RN documented that [Patient 1] was in her wheelchair with the posey on.

At 21:55 the Registrant documented in a handover note that [Patient 1] had somehow unsecured her posey, had fallen from the chair and was found on hands and knees. The Registrant further noted that there were no apparent injuries and although [Patient 1] had a bump on her head it was unlikely that it occurred from this incident due to the position she was found.

The Registrant did not complete an adequate post-fall assessment of [Patient 1] and did not manage the patient's fall in accordance with the protocol established in the AHS Falls Risk Management Post-Falls Review document. More specifically, the Registrant did not conduct a comprehensive head-to-toe assessment of [Patient 1], did not assess or document [Patient 1]'s neurological vital signs at 20:00 or thereafter, did not assess and/or document [Patient 1]'s vital signs at 20:00 or thereafter and did not notify the physician of the fall. In addition, the Registrant did not complete any post-falls assessment documentation regarding [Patient 1]'s fall.

The Registrant notified the Charge RN of [Patient 1]'s fall through an electronic sticky note in Connect Care but no verbal report was communicated by the Registrant to the Charge RN. The Registrant did not contact the physician or [Patient 1]'s family at the time of the fall or thereafter.

At or around 07:15 on June 16, 2022, [Patient 1] was received into care by another RN who was later approached by a physician. The RN documented that [the physician] approached them to discuss an unreported fall the previous evening of [Patient 1] and noted that the current shift had received no report of the fall nor any follow-up regarding same. The RN further documented that, upon review of notes, the Registrant does discuss a fall but that no assessment/post-falls assessment was undertaken nor was a diagnostic imaging request made. In addition, no vital signs taken at the time were recorded. The RN also documented that the Charge RN and assistant head nurse were notified regarding these findings and that [Patient 1] was being readied for a computed tomography (CT) scan of the head. Finally, the RN documented that [Patent 1]'s daughter was updated on the occurrence when she arrived.

The Physician assessed [Patient 1] at 10:15 on June 16, 2022. The Physician charted that the bruising on the back of [Patient 1]'s head was new, and since she was on direct oral anti-coagulant ("DOAC"), the physician was, "concerned there [was] a hematoma to the occiput." The Physician further documented as follows, "1-2 cm sized bruising to the back of the head that the pt complains is painful. I will hold DOAC and will send her for urgent CT".

In the same clinical note, the Physician documented that they communicated with the unit manager that the patient could not continue to stay in the hospital with no active medical issues requiring hospitalization and that there was a need for a placement with maximum falls precautions. The patient was noted as "impulsive" with "the capacity to get up by herself." They further noted that [Patient 1], "doesn't have good balance though so she ends up falling" and had a history of falls.

[Patient 1]'s family was informed of the fall the morning of June 16, 2022. [Patient 1] was sent for an urgent CT scan. The CT scan did not show intracranial hemorrhage but did show a new sign of ischemic stroke (L frontal) compared to previous imaging in April 2022. [Patient 1]'s daughter was made aware of these findings. The Registrant did not complete a reporting and learning system submission at the time of the fall on June 15, 2022, but rather on her next work day, June 25, 2022, along with a late nursing note.

Findings of the Hearing Tribunal

The Hearing Tribunal finds that the Allegations in the Notice of Attend are proven based on the admissions of the Registrant in the Agreement (including supporting materials) and at the hearing.

The Hearing Tribunal finds that the Registrant failed to adequately complete a post-falls assessment of [Patient 1] and failed to document post-fall vital signs (including neurological vital signs). The Hearing Tribunal further finds that the Registrant failed to notify critical team members of [Patient 1]'s fall including [Patient 1]'s physician, Charge Nurse and family. Finally, the Registrant failed to adequately document the post-fall care of [Patient1] in the patient's electronic medical record.

Nurses are expected to know, understand, and follow the policies and procedures of their workplace and to apply their skills and experience appropriately. Patient 1 was especially vulnerable as a patient who had a history of falls, and was on DOAC, which increases the gravity of harm if a patient experiences a fall. While the Registrant did acknowledge awareness of the "bump" on the back of [Patient 1]'s head, the subsequent determination that it was not related to the fall and decision not to proceed with further investigation and notification, displayed a lack of knowledge, skill and judgment. The error in assessment and lack of further follow-up based on that erroneous assessment are very troublesome. The Registrant's additional failure to communicate appropriately with team members in order to ensure continuity of care is also serious.

The AHS Policies provided, and the best-practices identified, have been put in place to protect all patients from the potentially serious consequences of an accidental fall and the Registrant's failure to follow and respect these policies displays a lack of knowledge, skill or judgment. Finally, the Registrant's failure to appropriately document and record her findings also displayed a lack of knowledge, skill or judgment. Documentation is a basic and fundamental skill required of all registrants.

In all of these circumstances, the Hearing Tribunal finds that the Conduct in Allegation 1 displayed a lack of knowledge, skill and judgment in the provision of professional services relevant to falls and post-falls care, contrary to section 1(1)(pp)(i) of the HPA.

The Hearing Tribunal also finds that the Conduct in Allegation 1 breached the following Standards of Practice and Code of Ethics, contrary to section 1(1)(pp)(ii) of the HPA.

Canadian Nurses Association Code of Ethics (2017)

The Hearing Tribunal finds that the Registrant's Conduct in Allegation 1 breached Responsibilities A1, A5, B4, D6, G1, G4 of the CNACE as follows:

A. Providing Safe, Compassionate, Competent and Ethical Care

Nurses provide safe, compassionate, competent and ethical care.

Ethical responsibilities:

1. Nurses have a responsibility to conduct themselves according to the ethical responsibilities outlined in this document and in practice standards in what they do

and how they interact with persons receiving care and other members of the **health-care team**.

5. Nurses are honest and take all necessary actions to prevent or minimize patient safety incidents. They learn from near misses and work with others to reduce the potential for future risks and preventable harms (see Appendix B).

B. Promoting Health and Well-Being

Nurses work with persons who have health-care needs or are receiving care to enable them to attain their highest possible level of health and well-being.

Ethical responsibilities:

4. Nurses collaborate with other health-care providers and others to maximize health benefits to persons receiving care and with health-care needs and concerns, recognizing and respecting the knowledge, skills and perspectives of all.

D. Honouring Dignity

Nurses recognize and respect the intrinsic worth of each person.

Ethical responsibilities:

6. Nurses utilize practice standards, best practice guidelines, policies and research to minimize risk and maximize safety, well-being and/or dignity for persons receiving care.

G. Being Accountable

Nurses are accountable for their actions and answerable for their practice.

Ethical responsibilities:

1. Nurses, as members of a self-regulating profession, practise according to the values and responsibilities in the *Code* and in keeping with the professional standards, laws and regulations supporting ethical practice.

4. Nurses are accountable for their practice and work together as part of teams. When the acuity, complexity or variability of a person's health condition increases, nurses assist each other (LPNAPEI et al., 2014).

CRNA's Practice Standards for Regulated Members (2013)

The Hearing Tribunal finds that the Registrant's Conduct in Allegation 1 breached Standards 1.1, 1.2, 1.4, 2.1, 2.2, 2.3, 2.4, 2.5, 2.7, 3.4, 4.1, 4.2, 4.3, 4.4, 5.2 and 5.3 of the CPSRM as follows:

Standard 1: Responsibility and Accountability

The nurse is personally responsible and accountable for their nursing practice and conduct.

Indicators

1.1 The nurse is accountable at all times for their own actions.

1.2 The nurse follows current legislation, standards and policies relevant to their practice setting.

1.4 The nurse practices competently.

Standard 2: Knowledge-based Practice

The nurse continually acquires and applies knowledge and skills to provide competent, evidence-informed nursing care and service.

Indicators

2.1 The nurse supports decisions with evidence-based rationale.

2.2 The nurse uses appropriate information and resources that enhance client care and the achievement of desired client outcomes.

2.3 The nurse uses ***critical inquiry*** in collecting and interpreting data, planning, implementing and evaluating all aspects of their nursing practice.

2.4 The nurse exercises reasonable judgment and sets justifiable priorities in practice.

2.5 The nurse documents timely, accurate reports of data collection, interpretation, planning, implementation and evaluation of nursing practice.

2.7 The nurse applies nursing knowledge and skill in providing safe, competent, ethical care and service.

Standard 3: Ethical Practice

The nurse complies with the *Code of Ethics* adopted by the Council in accordance with Section 133 of HPA and CARNA bylaws (CARNA, 2012).

Indicators

3.4 The nurse communicates effectively and respectfully with clients, significant others and other members of the ***health care team*** to enhance client care and safety outcomes.

Standard 4: Service to the Public

The nurse has a duty to provide safe, competent and ethical nursing care and service in the best interest of the public.

Indicators

4.1 The nurse coordinates client care activities to promote continuity of ***health services***.

4.2 The nurse collaborates with the client, significant others and other members of the health-care team regarding activities of care planning, implementation and evaluation.

4.3 The nurse effectively assigns care or nursing service and supervises others when appropriate or required to enhance client outcomes.

4.4 The nurse explains nursing care to clients and significant others.

Standard 5: Self-Regulation

The nurse fulfills the professional obligations related to self-regulation.

Indicators

5.2 The nurse follows all current and relevant legislation and regulations.

5.3 The nurse follows policies relevant to the profession as described in CARNA standards, guidelines and position statements.

CRNA's Documentation Standards for Regulated Members (2013)

The Hearing Tribunal finds that the Conduct in Allegation 1 breached Standards 1.1, 1.2 and 1.4 of the CDSRM as follows:

Standard 1

Nurses document the nursing care they provide accurately and in a timely, factual, complete and confidential manner.

Criteria:

The nurse must:

1.1 Record a complete account of nursing assessment of the client's needs, including:

a. identified issues and concerns
b. assessment findings
c. diagnosis
d. plan of care
e. intervention(s) provided
f. evaluation of the client care outcomes

1.2 Document the following aspects of care:

a. relevant objective information related to client care
b. the time when assessments and interventions were completed
c. follow-up of client assessments, observations or interventions that have been completed
d. the administration of medications after administration
e. formal and informal educational/teaching activity provided to the client and family
f. any adverse event or **adverse outcome**

1.4 Record:

a. legibly, in English, using clear and established terminology
b. accurately, completely and objectively
c. …
d. chronologically, the client **encounter** with the health system
e. **contemporaneously**
f. late entries at the next available opportunity, clearly identified as such, and include any additional requirements as defined by practice setting policy

CRNA's Entry Level Competencies for the Practice of Registered Nurses (2019)

The Hearing Tribunal finds that the Conduct in Allegation 1 breached Competencies 1.1, 1.2, 1.4, 1.5, 1.6, 1.7, 1.8, 2.1, 2.3, 2.13, 3.7, 3.8, 4.1, 4.3, 5.1, 7.1 and 7.6 of the CELCPRN as follows:

Competency Category 1: Clinician

Registered nurses are clinicians who provide safe, competent, ethical, compassionate, and evidence-informed care across the lifespan in response to client needs. Registered nurses integrate knowledge, skills, judgment and professional values from nursing and other diverse sources into their practice.

Competencies:

1.1 Provides safe, ethical, ***competent***, ***compassionate***, ***client-centered*** and ***evidence-informed*** nursing care across the lifespan in response to ***client*** needs.

1.2 Conducts a ***holistic*** nursing ***assessment*** to collect comprehensive information on client health status.

1.4 Analyses and ***interprets*** data obtained in client assessment to inform ongoing decision-making about client health status.

1.5 Develops ***plans of care*** using ***critical inquiry*** to support professional judgment and reasoned decision-making

1.6 Evaluates effectiveness of plan of care and modifies accordingly.

1.7 Anticipates actual and potential health risks and possible unintended outcomes.

1.8. Recognizes and responds immediately when client safety is affected.

Competency Category 2: Professional

Registered nurses are professionals who are committed to the health and well-being of clients. Registered nurses uphold the profession's practice standards and ethics and are accountable to the public and the profession.

Competencies:

2.1 Demonstrates ***accountability***, accepts responsibility, and seeks assistance as necessary for decisions and actions within the legislated ***scope of practice***.

2.3 Exercises professional judgment when using agency policies and procedures, or when practising in their absence.

2.13 Recognizes, acts on, and reports ***harmful incidences***, ***near misses***, and ***no harm incidences***.

Competency Category 3: Communicator

Registered nurses are communicators who use a variety of strategies and relevant technologies to create and maintain professional relationships, share information, and foster therapeutic environments.

Competencies:

3.7 Communicates effectively in complex and rapidly changing situations.

3.8 Documents and reports clearly, concisely, accurately, and in a timely manner.

Competency Category 4: Collaborator

Registered nurses are collaborators who play an integral role in the health-care team partnership.

Competencies:

4.1 Demonstrates collaborative professional relationships

4.3 Determines their own professional and ***interprofessional*** role within the team by considering the roles, responsibilities, and the scope of practice of others.

Competency Category 5: Coordinator
Registered nurses coordinate point-of-care health service delivery with clients, the health-care team, and other sectors to ensure continuous, safe care.

Competencies:

5.1 Consults with clients and health-care team members to make ongoing adjustments required by changes in the availability of services or client health status.

Competency Category 5: Advocate

Registered nurses are advocates who support clients to voice their needs to achieve optimal health outcomes. Registered nurses also support clients who cannot advocate for themselves.

Competencies:

7.1 Recognizes and takes action in situations where client safety is actually or potentially compromised.

7.6 Advocates for safe, competent, compassionate and ethical care for clients.

The breaches of the Code of Ethics (CNACE) listed above are serious. In failing to provide appropriate and contemporaneous post-fall care to [Patient 1], the Registrant negated her ethical responsibility to prevent or minimize the incident, collaborate with team members and implement best practices to maximize [Patient 1]'s safety and well-being.

Similarly, the Registrant's failure to follow the AHS Falls Risk Management Policy (Level 1) and Appendix E2: AHS Falls Risk Management Post-Falls Review document is a serious breach of her obligations under the CPSRM. The Registrant's failure to apply and follow relevant standards and policies and to appropriately integrate the acquired knowledge, skills, and judgment required to provide care to [Patient 1] was a serious breach of the obligation owed to [Patient 1] following the un-witnessed fall. The Registrant had a duty to provide safe and competent nursing care to [Patient 1], to collaborate appropriately with team members in order to promote continuity of care and to keep [Patient 1]'s significant others informed following [Patient 1]'s fall. All of the above are in contravention of the CPSRM as well as the competencies expected of nurses under the above sections of the CELCPRN.

Finally, with respect to documentation, the failure of the Registrant to properly document a post-fall assessment are serious breaches of the CDSRM. The Registrant's submission in the reporting and learning system 10 days after the incident, along with a late nursing note, is in clear breach of CDSRM's requirement that documentation be completed contemporaneously.

The admitted Conduct is clearly in breach of the ethics, standards and competencies expected of nurses, as explained above. The Hearing Tribunal therefore finds that these breaches are serious and constitute unprofessional conduct pursuant to section 1(1)(pp)(ii) of the HPA.

SUBMISSIONS ON SANCTION

The Hearing Tribunal heard submissions on sanction.

Statement by the Registrant:

The Registrant was affirmed and made a statement expressing her remorse. She stated that she has been an RN for 20 years and in that time has been in good standing with CRNA. She comes from a long line of nurses and what she has always valued and loved about the nursing profession was the opportunity to help and care for others, to provide compassion, to be an advocate for her patients and to provide patient and family-centred care.

She stated that she understands that on the evening in question she made practice errors and failed to meet the standards expected of her. She failed to complete the proper assessments and documentation. She further noted that the evening in question and the CRNA process has been

a learning experience for her and she expressed deep remorse for her actions. She assured the Tribunal that it was not her intent to make these mistakes. The Registrant states that she has always strived to live up to her professional practice standards and will continue to do so in the future. She has already begun work on the proposed sanctions and has completed number 3 (the readings). Finally, she stated that she regrets her actions and that it is always her goal to give her patients the best patient care she can. On this occasion, she failed to do so and for that she is truly sorry.

Submissions by Conduct Counsel:

Conduct Counsel noted there was a joint proposal on sanction and reviewed the Joint Recommendations on Sanction (Exhibit #3) ("JRS"). He submitted that the parties have presented a penalty that is designed to protect the public and maintain confidence in the profession. It also sends the appropriate message to other members of the regulated profession. He noted that denunciation and deterrence are legitimate factors in setting sanction but that the ultimate sanction must be measured, proportionate and reasonable.

Conduct Counsel reviewed the factors delineated in *Jaswal* to explain why the parties' proposed JRS is appropriate in the circumstances.

1. The nature and gravity of the proven allegations: the conduct is serious in that falls have to be handled appropriately in order to ensure protection of the public.

2. The age and experience of the member: the Registrant has been registered since November 2004 and should be aware of her responsibilities, ethical and otherwise.

3. The previous character of the member: the Registrant has no prior discipline history with the College.

4. The age and mental condition of the offended patient: the patient was 85 at the time of the conduct and was suffering from dementia.

5. The number of times the offence was proven to have occurred: The conduct occurred on June 15th, 2022.

6. The role of the registered nurse in acknowledging what occurred: The Registrant has admitted to the allegations and that they constitute unprofessional conduct. Her cooperation, accountability and acceptance of responsibility is very significant and mitigating.

7. Whether the member has already suffered other serious financial or other penalties: The Registrant has not suffered serious financial or other penalties as a result of the allegations.

8. The impact on the offended patient: There is not direct evidence on patient impact, but the outcome could have potentially been better for the patient if the registrant had taken the proper post-fall steps.

9. The presence or absence of any mitigating factors: none

10. The need to promote specific and general deterrence: general deterrence is paramount and ensuring that other nurses are aware of proper post-fall procedures is important. This includes following relevant employer policy and the importance of adequate documentation. The specific deterrence is the need to impose a sanction on the Registrant to ensure she does not repeat the conduct in the future. It is achieved by the reprimand in this situation.

11. The need to maintain public confidence: The JRS sends an appropriate message to the public about the importance of following post-fall procedure.

12. Degree to which offensive conduct is outside the range of permitted conduct: clearly the conduct was unacceptable, and the registrant has admitted that the conduct was unprofessional conduct.

Conduct Counsel noted the case of *R. v. Anthony Cook*, 2016 SCC 43 ("*Anthony Cook*") and the authority it provides regarding deference to a joint submission on penalty. In his submission, the agreed upon sanction balances rehabilitation and deterrence and would not bring the administration of justice into disrepute. It is not contrary to the public interest.

Submissions by the Labour Relations Officer for the Registrant:

The Labour Relations Officer submitted that, as noted, the Registrant has no history of discipline with the College and has taken accountability throughout this process. The Registrant did not want to send this to a contested hearing and has worked with counsel to come to an agreement. The sanction is more than reasonable in balancing deterrence and protecting the public. What has been outlined does provide learning opportunities and an opportunity for self-reflection for the Registrant. There is now something in place to ensure that going forward the Registrant will meet the standards required of an RN.

Questions from the Hearing Tribunal:

The Hearing Tribunal requested clarification regarding a missing word under 7(b). Conduct Counsel agreed that the word "be" is missing and the relevant portion should read "… and such nursing practice hours cannot <u>be</u> earlier than the date of approval of the First Employer Reference."

The Hearing Tribunal then requested clarification regarding Schedule "C" and the reference to the "execution of a complaint resolution." Following a brief adjournment, the parties advised that the correct wording in paragraph 5 of the JRS should read:

> <u>Within 30 days of the written hearing order being issued</u>, the Registrant shall provide a letter ("**Practice Setting Letter**") to the Complaints Director from the Registrant's RN or NP Supervisor (the "**Supervisor**") at their current place of employment ("**Practice Setting**"), confirming …

DECISION AND REASONS OF THE HEARING TRIBUNAL ON SANCTION

The Hearing Tribunal carefully considered the submissions of the parties, as well as the factors outlined by Conduct Counsel in *Jaswal*. Given the Registrant's seniority and experience, she should have been aware of the specific requirements and obligations required following an unwitnessed fall in an elderly patient. Her failure to properly fulfill her responsibilities on the

evening in question was a serious breach. The Registrant's willingness to take full accountability for her mistakes and to cooperate with the College are significant mitigating factors.

The Hearing Tribunal also reviewed each proposed order and finds that they are appropriate in the circumstances. The Reprimand will maintain confidence in the profession and serves as both specific and general deterrence. The remedial portions of the JRS, including the two specific educational courses, readings and self-improvement plan are appropriate and will assist the Registrant in improving her skills and ensuring that conduct of this nature is not repeated. Finally, the orders relating to employer reference letters, including elements of supervision, will serve to further protect the public and aid the Registrant in her remediation.

The Hearing Tribunal considered the requirements set out in *Anthony Cook* and determined that the JRS reflects the seriousness of the findings and protects the public interest. It further agrees that the JRS balances rehabilitation and deterrence, will not bring the administration of justice into disrepute and is not contrary to the public interest. In light of the above, the Hearing Tribunal accepts the JRS as proposed with the small wording changes reflected above under "Questions from the Hearing Tribunal." These changes have been incorporated below as part of the Hearing Tribunal's Order.

ORDER OF THE HEARING TRIBUNAL

The Hearing Tribunal orders that:

1. The Registrant shall receive a reprimand for unprofessional conduct.

2. By **February 15, 2025**, the Registrant shall provide proof of completion, satisfactory to the Complaints Director, that they have successfully completed and passed the following courses of study and learning activities:

    a. Introduction to Health Assessment (NURS0163 – MacEwan University); and

    b. Documentation in Nursing (NURS0162 – MacEwan University).

3. By **February 15, 2025**, the Registrant shall provide a written declaration to the Complaints Director, in the form attached as "**Schedule A**" to this Order, confirming that they have read and reviewed:

    a. the Canadian Nurses Association Code of Ethics for Registered Nurses (2017);

    b. the Documentation Standards (2022);

    c. the Practice Standards for Registrants (2023); and

    d. the Entry-Level Competencies for the Practice of Registered Nurses (2019).

4. By **February 15, 2025**, the Registrant shall provide to the Complaints Director a self-improvement plan for post fall management ("**Behavior Improvement Plan**") and the Behavior Improvement Plan must be satisfactory to the Complaints Director and must:

    a. Be typed and comply with professional formatting guidelines (American Psychological Association style);

    b. Be at least five hundred (500) words in length;

    c. Include a list of three (3) goals of self-improvement relating to post-fall assessment and management, specifically:

        1. Describe how the Registrant will improve their practice, including strategies, plans and supports or resources that may assist their improvement; and

        2. Cite at least three (3) applicable standards and responsibilities from the following:

            a. the *Documentation Standards;*

            b. the *Practice Standards;* and

            c. the *Code of Ethics.*

5. Within 30 days of the written hearing order being issued, the Registrant shall provide a letter ("**Practice Setting Letter**") to the Complaints Director from the Registrant's RN or NP Supervisor (the "**Supervisor**") at their current place of employment ("**Practice Setting**"), confirming:

    a. The Supervisor's name and contact information;

    b. The Practice Setting;

    c. The Registrant's role of employment;

    d. That the Supervisor has reviewed the written Hearing Order; and

    e. That the Supervisor agrees to provide to the College **two (2) Employer References** following the terms and conditions in paragraph 6 and 7.

6. The Registrant shall provide the first Employer Reference from their Supervisor **thirty (30) days** after their Practice Setting Letter is approved by the Complaints Director

(the "**First Employer Reference**"). The Employer Reference must be acceptable to the Complaints Director and must adhere to the following requirements:

a. The First Employer Reference be on the form attached as "**Schedule B**" and must include confirmation of all information required in the Employer Reference Form;

b. The First Employer Reference must confirm whether the Registrant has completed at least **seventy-five (75) hours** of nursing practice within the last **thirty (30) days**, and such nursing practice hours cannot occur earlier than the date of the written Hearing Order;

c. The Registrant shall be under **indirect supervision** for the duration of the First Employer Reference This means that the Registrant can never be the only RN on duty on the unit, and that there must always be at least one other RN/NP working with them, on the same shift, on the same unit, available to the Registrant throughout the entire shift to answer the Registrant's questions and provide assistance as the Registrant requests, or as the Supervisor deems necessary (see the Supervision Standards (2022));

d. The Supervisor will personally observe and obtain feedback from other RNs/NPs who are on the same unit for the shifts that the Registrant is working who have ample opportunities to observe all aspects of the Registrant's nursing practice;

e. The Supervisor will also obtain feedback from other members of the health care team, patients and patient families;

f. The Supervisor must conduct chart audits to verify the Registrant's practice during the First Employer Reference.

7. The Registrant shall provide the second Employer Reference from their Supervisor **ninety (90) days** after their first Employer Reference is approved by the Complaints Director (the "**Second Employer Reference**"). The Second Employer Reference must be acceptable to the Complaints Director and must adhere to the following requirements:

a. The Second Employer Reference be on the form attached as "**Schedule C**" and must include confirmation of all information required in the Employer Reference Form;

b. The Second Employer Reference must confirm whether the Registrant has completed at least **one hundred eighty (180) hours** of nursing practice within the last **ninety (90) days**, and such nursing practice hours cannot be earlier than the date of approval of the First Employer Reference;

c. The Supervisor must indicate whether concerns exist about the Registrant's practice and whether they met or exceeded the standards expected of a RN.

8. Until the Registrant has submitted the final Employer Reference to the Complaints Director, as required by paragraph 7, and it is deemed satisfactory to the Complaints Director, the Registrant shall not be employed in any other setting except the Practice Setting(s) approved by the Complaints Director, unless:

   a. The Registrant submits an updated Practice Setting Letter to the Complaints Director from their prospective employer detailing the new Practice Setting, and following the requirements in paragraph 5 and that acknowledges that the Supervisor is prepared to provide any outstanding Employer Reference(s) as required in paragraphs 6 or 7, or as directed by the Complaints Director; and

   b. The Complaints Director, acting reasonably, acknowledges receipt of the letter and deems it satisfactory.

(the "**Condition(s)**")

COMPLIANCE

9. Compliance with this Order shall be determined by the Complaints Director of the College. All decisions with respect to the Registrant's compliance with this Order will be in the sole discretion of the Complaints Director.

10. The Registrant will provide proof of completion of the above-noted Conditions to the Complaints Director via e-mail to procond@nurses.ab.ca or via fax at 780-453-0546.

11. Should the Registrant fail or be unable to comply with any of the requirements of this Order, or if any dispute arises regarding the implementation of this Order, the Complaints Director may exercise the authority under section 82(3) of HPA.

12. The responsibility lies with the Registrant to comply with this Order. It is the responsibility of the Registrant to initiate communication with the College for any anticipated non-compliance and any request for an extension.

CONDITIONS

13. The Registrant confirms the following list sets out all the Registrant's employers and includes all employers even if the Registrant is under an undertaking to not work, is on sick leave or disability leave, or if the Registrant have not been called to do shifts, but could be called. Employment includes being engaged to provide professional services as

a Registered Nurse on a full-time, part-time, casual basis as a paid or unpaid employee, consultant, contractor or volunteer. The Registrant confirms the following employment**:**

Employer Name	**Employer Address & Phone Number**
Alberta Health Services	Fort Saskatchewan Community Hospital 9401 86 Avenue Fort Saskatchewan, AB T8L 0C6

14. The Registrant understands and acknowledges that it is the Registrant's professional responsibility to immediately inform the College of any changes to the Registrant's employers, and employment sites, including self-employment, for purposes of keeping the Registrar current and for purposes of notices under section 119 of the HPA.

15. The Registrar of the College will be requested to put the following conditions against the Registrant's practice permit (current and/or future) and shall remain until the conditions are satisfied:

    a. **Course work required – Arising from Disciplinary Matter;**

    b. **Behavior Improvement Plan required – Arising from Disciplinary Matter;**

    c. **Confirmation of Practice Setting(s) required - Arising from a Disciplinary Matter;**

    d. **Employer Reference(s) (indirect supervision) required – Arising from a Disciplinary Matter;**

    e. **Employer Reference(s) (Practice Report) required – Arising from Disciplinary Matter;**

    f. **Restriction re Practice Setting – Arising from Disciplinary Matter.**

16. Effective on the date of the Hearing, which is to be determined, or the date of this Order if different from the date of the Hearing, notifications of the above condition shall be sent out to the Registrant's current employers (if any), the regulatory college for Registered Nurses in all Canadian provinces and territories, and other professional colleges with which the Registrant is also registered (if any).

17. Once the Registrant has complied with a condition listed above, it shall be removed. Once all the conditions have been removed, the Registrar will be requested to notify the regulatory colleges in the other Canadian jurisdictions.

18. This Order takes effect on the date of the Hearing, which is to be determined, and remains in effect pending the outcome of any appeal, unless a stay is granted pursuant to section 86 of the HPA.

This Decision is made in accordance with Sections 80, 82 and 83 of the HPA.

Respectfully submitted,

Bonnie Bazlik, Chairperson
On Behalf of the Hearing Tribunal

Date of Order: September 25, 2024